STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DING	00	COMPL	ETED
		155139	A. BUIL B. WING			12/16/2	011
			D. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			JEFFERSON ST		
NODTH \	WOODS VILLAGE				10, IN46901		
	WOODS VILLAGE			KOKOW			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	-	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was fo	or the Recertification and	F0	000			
	State licensure si	urvey. This visit included					
	the investigation	of complaint					
	#IN00101011.	r					
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	Compleint # INC	00101011: Substantiated:					
	•	00101011: Substantiated:					
		ficiencies related to					
	allegations are ci	ited at F 241.					
	Survey dates: D	ecember 13, 14, 15 and					
	16, 2011						
	,						
	Facility number:	000064					
	Provider number						
	AIM number: 10	00288770					
	Survey team:						
	Tammy Alley R	N TC					
	Donna M. Smith	ı RN					
	Toni Maley BSV	W (December 13, 14, and					
	15, 2011)	(
	Linn Mackey RN	NI					
	=	(December 14, 15, and					
	16, 2011)						
	Census bed type	:					
	SNF: 16						
	SNF/NF: 144						
	Total: 160						
	Conque novem to	no:					
	Census payor typ	pe.					
	Medicare: 42						
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: WBLM11 Facility ID:

000064

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
THIS TEATLY	or conduction	155139	A. BUILDING B. WING		12/16/2011
NAME OF B				ADDRESS, CITY, STATE, ZIP CODE	
	ROVIDER OR SUPPLIER			JEFFERSON ST	
NORTH \	WOODS VILLAGE		KOKON	MO, IN46901	
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE DATE
	Medicaid: 88				
	Other: 30				
	Total: 160				
	G1 24				
	Sample: 24 Supplemental Sa	mnla: 13			
	Supplemental Sa	impic. 13			
	These deficiencie	es also reflect state			
	findings cited in	accordance with 410 IAC			
	16.2.				
	Quality raviasy o	ompleted 12/20/11			
	Cathy Emswiller	_			
F0241	The facility must p	romote care for residents in			
SS=E	a manner and in a	n environment that			
		nces each resident's dignity recognition of his or her			
	individuality.	recognition of this of their			
	Based on record	review, observation and	F0241	The creation and submission	01/11/2012
		cility failed to ensure		this Plan of Correction does in constitute an admission by the	
		tained for Residents		provider of any conclusion se	
		ake choices when to rise y having them up before		forth in the statement of deficiencies, or of any violation	on of
		morning for 10 of 10		regulation.This provider	
		ed up and dressed in a		respectfully requests that the 2567 Plan of Correction be	!
		esident B, C, E, F, G, H,		considered the Letter of Cred	dible
		and for 5 of 5 residents		Allegation and requests a Po	st
	observed up and			Survey Review on or after January 11, 2012.	
	supplemental san J, K, L, and P)	mple of 13. Resident (D,		F241 Dignity	
	J, K, L, allu F)			It is the practice of this provide	der to

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WBLM11 Facility ID:

000064

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155139	B. WIN			12/16/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			/ JEFFERSON ST		
NORTH '	WOODS VILLAGE				MO, IN46901		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	ICY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		TAG		- d	DATE
	Findings include	:			ensure residents are providence in a manner and in an	ea	
					environment that maintains	or	
	1. The record for	r Resident B was			enhances each resident's d		
	reviewed on 12/2	14/11 at 8 a.m.			and respect in full recognition		
					his or her individuality. What		
	Current diagnose	es included, but were not			corrective action(s) will be		
	limited to, deme				accomplished for those		
	ininited to, define	iitia.			residents found to have be	en	
					affected by the deficient		
		erly Minimum Data Set			practice · Certified Nursing		
	Assessment (MI	OS) indicated the resident			Assistant (C.N.A.) #3 and #		
	was severely cog	gnitively impaired and			Licensed Practical Nurse (L	PN)	
	required total ass	sistance for transfer,			#2 was re-educated on appropriate times for reside	nte to	
	dressing and hyg	riene.			get up in the morning.	1113 10	
		,			Residents		
	On 12/13/11 at /	30 a.m., the resident was			B,C,D,E,F,G,H,I,J,K,L,N,O,I	o and	
					Q have been asked and/or t		
	•	chair in the second floor			responsible party have beer	1	
	_	n, fully dressed with his			asked on the residents norn		
		nis eyes closed. At that			time to rise in the morning.		
	time during inter	view, CNA # 6 indicated			list for residents to get up ea	•	
	he got the reside	nt up around 4 a.m., he			has been revised as to their individual preference. Sta		
	also indicated he	begins getting residents			schedule has been revised		
		d 4:30 a.m., daily.			accommodate the appropria		
		·- · · · · · · · · · · · · · · ·			up times. How will you ider	-	
	2 The record for	or Resident C was			other residents having the	-	
					potential to be affected by	the	
	reviewed on 12/	14/11 at 12:30 p.m.			same deficient practice an	d	
					what corrective action will		
	_	es included, but were not			taken · Residents that requ		
	limited to, deme	ntia.			staff assistance with getting		
					the morning have the poten	tial to	
	A 10/11/11 quar	terly MDS assessment			be affected by the alleged deficient practice. Nursing	staff	
	-	ident was cognitively			was re-educated on dignity		
	impaired and rec				appropriate times to get res		
	_	-			up in the morning on		
		insfers, dressing and			12-27-2011 with post test		
	hygiene.				·		

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL	
ANDILAN	or connection	155139	A. BUI	LDING	00	12/16/2	
		133139	B. WIN			12/10/2	011
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE JEFFERSON ST		
NORTH	WOODS VILLAGE				1O, IN46901		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	,		DATE
TAG	On 12/13/11 between his chair at the dieyes closed. This Alzheimer's care and alzheimer's care are assistance for training and required	ween 4:50 and 5:05 a.m., observed fully dressed in ining room table with his as resident resided on the funit. Tresident E was 14/11 at 12:30 p.m. The sincluded, but were not intia. The sincluded, but were not ident was cognitively quired extensive considers, dressing and The ween 4:50 and 5:05 a.m., served assisting Resident seed, to the bathroom. At turing an interview, CNA would start getting the veen 4:00 a.m. to 4:30 ont resided on the funit. Tresident F was 15/11 at 10 a.m. The sincluded, but were not		TAG	administered to evaluate rete of education by the Staff Development Coordinator (S · Individual preference for tir to get up in the morning have been reviewed and adjusted individual residents and care plans and C.N.A assignment sheets have been updated. Staff schedule was revised to accommodate the appropriat up times. Residents have to asked and/or their responsib party have been asked on the residents normal time to rise the morning. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. Staff was re-educated 12-27-2011, for dignity and appropriate times for resident get up in the morning by the · Individual preferences for the to get up in the morning have been revised for individual residents. Staff schedule we revised to accommodate the appropriate get up times. The individual resident preference is to get up is followed daily thow the corrective action(swill be monitored to ensure deficient practice will not reference, what quality assurance program will be put into plate. The CQI tool "Dignity and continuous plates and charge may will be put into plates."	ention DC). mes ef for De get ee get ee in s at don ts to SDC. imes e imes e the urses eeing eence the ecur,	DATE
	limited to, demen	ntia.			Accommodation of Needs wi	ll be	

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE : COMPL	
		155139	B. WIN			12/16/2	011
	PROVIDER OR SUPPLIER		•	2233 W	DDRESS, CITY, STATE, ZIP CODE JEFFERSON ST IO, IN46901		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
1.40	A 10/14/11 quart indicated the resi impaired and req assistance for dressistance for dressi	derly MDS assessment dent was cognitively uired extensive essing and hygiene. :40 a.m., the resident up fully dressed, sitting in is room. r Resident G was 5/11 at 10:15 a.m. es included, but were not natia. erly MDS assessment dent was cognitively uired total assistance for g and hygiene. :40 a.m., the resident was hair fully dressed in her r Resident H was 5/11 at 1:30 p.m. es included, but were not natia.			utilized by the Interdisciplinal Team weekly for four weeks, monthly for three months an quarterly thereafter. The Director of Nursing Services /or Designee is responsible to monitor for compliance. The CQI team reviews the audits monthly and action plans are developed as needed if three of 90% is not met to ensure continual compliance. Compliance date: January 2012	d and o e shold	

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	(X	(2) MULT	TIPLE CO	NSTRUCTION		(X3) DATE COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155139		. BUILDI	NG	00		12/16/2	
		100100	В.	WING				12/10/2	011
NAME OF I	ROVIDER OR SUPPLIER	₹				ADDRESS, CITY, STA			
NODTH V	WOODS VILLAGE					JEFFERSON S 10, IN46901	o I		
						10, 11140901			
(X4) ID		TATEMENT OF DEFICIENCIES			D EEEE		PLAN OF CORRECTION VE ACTION SHOULD BE		(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION			EFIX `AG	CROSS-REFERENCI	ED TO THE APPROPRIATICIENCY)	E	COMPLETION DATE
1710	and hygiene.	LESC IDEIVIII TIIVO IIVI ORUMATIOIV	.,	1	AG.				DATE
	and nygiche.								
	On 12/12/11 hots	ween 4:50 and 5:05 a.m.,							
		observed fully dressed in							
		d down in her chair							
		esident resided on the							
	Alzheimer's care	unit.							
	7 77 1.0	D :1 4 I							
	7. The record for								
	reviewed on 12/1	15/11 at 1:00 p.m.							
	G 1:								
	_	es included, but were not							
	limited to, Alzhe	eimer's Disease.							
	A 11/10/11	al MDS assessment							
		ident was cognitively							
		quired extensive to total							
		insfers, dressing and							
	hygiene.								
	0 - 12/12/11 1 - 4	4.50 15.05							
		ween 4:50 and 5:05 a.m.,							
		observed fully dressed in							
		lining room table with her							
	~	is resident resided on the							
	Alzheimer's care	e unit.							
	0.751 1.0	D :1 (M							
		or Resident N was							
	reviewed on 12/1	15/11 at 1:00 p.m.							
	G 4 1:								
	_	es included, but were not							
	limited to, Alzhe	eimer's Disease.							
	A 10/05/11	1.100							
	-	terly MDS assessment							
	indicated the resi	ident was cognitively							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID	: WBL	M11	Facility I	D: 000064	If continuation sh	neet Par	ge 6 of 26

	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155139	LDING	NSTRUCTION 00	<u> </u>	e survey Pleted 2011
	PROVIDER OR SUPPLIER		STREET A	.DDRESS, CITY, STATE, ZIP C JEFFERSON ST IO, IN46901	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
		uired extensive to total nsfers, dressing and				
	Resident N was of dressed sitting in	ween 4:50 and 5:05 a.m., observed awake and fully her w/c at a dining room ent resided on the unit.				
		r Resident O was 15/11 at 1:50 p.m.				
	Current diagnose limited to, Alzhe	es included, but were not imer's Disease.				
	assessment indic cognitively impa	icant change MDS ated the resident was ired and required total nsfers, dressing and				
	Resident O was of her w/c asleep in	ween 4:50 and 5:05 a.m., observed fully dressed in the dining room. This on the Alzheimer's care				
		or Resident Q was 14/11 at 9:50 a.m.				
	Current diagnose limited to, demen	es included, but were not ntia.				

000064

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155139	B. WIN	G		12/16/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
NAME OF I	ROVIDER OR SULLEIE			2233 W	JEFFERSON ST		
NORTH '	WOODS VILLAGE			KOKON	/IO, IN46901		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE	COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	erly MDS assessment					
		ident was cognitively					
	impaired and rec	•					
		insfers, dressing and					
	hygiene.						
	0.10/10/11	4.50 1.505					
		ween 4:50 and 5:05 a.m.,					
	-	s observed fully dressed					
		to the dining room table.					
		e during an interview,					
		ed he was responsible for					
	_	nts on the Birch Lane					
	,	e unit) up before his shift					
		n. This resident resided					
	on the Alzheime	r's care unit.					
	11 771 11						
		for Resident D was					
	reviewed on 12/	14/11 at 2:30 p.m.					
	Current diagnose	es included, but were not					
	limited to, deme	*					
	minica to, defile	iiia.					
	Δ 10/11/11 quar	terly MDS assessment					
	•	ident was cognitively					
	impaired and rec	• •					
		unsfers, dressing and					
	hygiene.	misters, dressing and					
	nygiche.						
	On 12/13/11 het	ween 4:50 and 5:05 a.m.,					
		observed fully dressed					
		ed with his eyes closed.					
		e during an interview,					
		ed the CNA's had to dress					
		is resident resided on the					
	me resident. Th	is resident resided on the					

000064

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155139	(X2) MU A. BUII B. WIN	LDING	nstruction 00	(X3) DATE (COMPL 12/16/2	ETED
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE JEFFERSON ST		
NORTH \	WOODS VILLAGE				IO, IN46901		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Alzheimer's care	unit.					
	12. The record f reviewed on 12/1	For Resident J was 15/11 at 11 a.m.					
	Current diagnose limited to, demen	es included, but were not ntia.					
	indicated the resimpaired and req	terly MDS assessment ident was cognitively uired extensive nsfers, dressing and					
	Resident J was o wheelchair with	ween 4:50 and 5:05 a.m., bserved dressed in her her eyes closed sitting in is resident resided on the unit.					
	13. The record f	For Resident K was 15/11 at 11 a.m.					
	Current diagnose limited to, Alzhe	es included, but were not imer's Disease.					
	indicated the resi	terly MDS assessment ident was cognitively quired limited to extensive nsfers, dressing and					
		ween 4:50 and 5:05 a.m., observed fully dressed					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155139	LDING	ONSTRUCTION 00	(X3) DATE COMPL 12/16/2	ETED
NAME OF F	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP CODE JEFFERSON ST		
NORTH	WOODS VILLAGE		KOKOM	1O, IN46901		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
		wn sitting on the couch in is resident resided on the unit.				
	14. The record to reviewed on 12/	for Resident L was 15/11 at 11 a.m.				
	Current diagnose limited to, Alzhe	es included, but were not eimer's Disease.				
	indicated the res impaired and rec	terly MDS assessment ident was cognitively quired limited to extensive ansfers, dressing and				
	Resident L was of her wheelchair (ween 4:50 and 5:05 a.m., observed fully dressed in w/c) with audible snoring dent resided on the e unit.				
		for Resident P was 15/11 at 1:15 p.m.				
	Current diagnose limited to, deme	es included, but were not ntia.				
	indicated the res impaired and rec	erly MDS assessment ident was cognitively quired extensive ansfers, dressing and				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155139	(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION 3 00	(X3) DATE COMPI 12/16/2	LETED
	PROVIDER OR SUPPLIER		223	REET ADDRESS, CITY, STATE, ZIP CODE 33 W JEFFERSON ST DKOMO, IN46901		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
	Resident P was ordressed with a claim in the direction resided cunit.	ween 4:50 and 5:05 a.m., bserved awake and fully oth protector on sitting in ining room. This on the Alzheimer's care elates to the investigation 100101011.				
F0252 SS=C	comfortable and hallowing the reside personal belonging Based on observation facility failed to clean and in good and peeling wally sills, accumulation around baseboard	rovide a safe, clean, omelike environment, ent to use his or her gs to the extent possible. ation and interview, the ensure the facility was d repair related to torn paper, broken window on of gray brown dirt ds, missing floor tiles, spots on ceiling tiles.	F0252	F252 Safe/Clean/Comfortable/ ke Environment It is the practice of this pro- ensure residents are prov with a safe, clean, comfor and homelike environmen allowing the resident to us	ovider to ded table t,	01/11/2012

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155139	(X2) MULTI A. BUILDIN B. WING	G <u>00</u>		(X3) DATE SURVEY COMPLETED 12/16/2011	
	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN46901				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREI	CROS	ACH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETI	
TAG		R LSC IDENTIFYING INFORMATION)	TA	.0		Ditte	
	•	ctice had the potential to			personal belongings to the ent possible.	e	
		0 residents who reside in		EXI	ent possible.		
	the building:			Wh	at corrective action(s) wi	II	
					accomplished for those		
	Findings include	e:		res	idents found to have bee	n	
				affe	ected by the deficient		
	During the envir	ronmental tour on		pra	ctice		
	12/15/11 at 9:50			· ·	Wallpaper has been aired and /or replaced in		
	Maintenance Di			_	aired and /or replaced in auty Shop, Room #247,#2	46	
		Service Director the			Desk has been repaire		
	following was o			Hal	I way to Therapy.		
	Tollowing was o	oserved.			Grey/Brown build up ha	as	
	The Decrete of a	. h . d li ll			en cleaned/repaired on		
	1	p had peeling wallpaper			seboard and/or flooring for		
		socket on the inside wall.			ple Lane, Room #117, -0,#222,#233, A hall,		
		llway going to the therapy			ncentrator in Room #117		
		g trim around the top of			aned, and visitors elevator		
	the desk area.				Window seal repaired i		
				nd 1	floor lounge and Room #2		
	The hallway on	Maple Lane had an			Lamp Shade replaced	on	
	accumulation of	gray brown dirt around		lam	p in 2 nd floor lounge. Ceiling tile and wall in		
	the base boards.			Roo	om #220 has been		
					aired/replaced.		
	The visitor eleva	ator had 3 nicks in the 12					
		e nick in the middle of the			w will you identify other	.	
	1 -	ximately 3 inches (in) by 2			idents having the potenti	al	
		nowing through the nick.			be affected by the same icient practice and what		
		to the elevator door was			rective action will be take	en	
		2 in by 2 in. The third		.	Residents who reside i		
	11	back of the elevator and			facility have the potential	to be	
					ected by the alleged deficie	ent	
	was approximat	ely .5 inches in length.		pra	ctice.		
	117 117 1	1.41		Mai	Staff including intenance and Housekeep	ing	
	· ·	e bathroom entrance had a			pervisors have been	"' ⁹	
	1	brown dirt around the			educated on 12-27-201 wit	:h	
	base boards. Th	ne oxygen concentrator					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155139 12/16/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2233 W JEFFERSON ST NORTH WOODS VILLAGE KOKOMO, IN46901 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE had a yellowish half dollar size dry post test administered to evaluate the retention of substance on the top. The floor under the education by SDC on observing tube feeding pump had a yellowish dry rooms, hallways and equipment substance spattered on the floor. The needing repair, cleaning, or replaced and to complete floor was sticky when walked on. necessary maintenance slips for repair/replacement when needed. In the second floor resident's lounge, a lamp shade was noted to be held together What measures will be put into by paper tape. Also in the lounge was a place or what systemic changes you will make to broken window sill. The Maintenance ensure that the deficient Director indicated it was a knot hole in practice does not recur the wood. Preventive Maintenance schedule will be followed to The Hallway on the A wing had a build identify areas of repair and/or replacement by Maintenance and up of gray brown dirt around the entire Housekeeping Departments. baseboards. Also observed on A wing **Customer Care** was: Representative will monitor on daily rounds and report accordingly. Room 240 the baseboard was off by the Staff re-educated bathroom, the window sill was loose and 12-27-2011 on completing broken. maintenance slips when areas or Room 247 had peeling wallpaper on the items are in need of repair or replacement. with post test outside wall. administered to evaluate the Room 246 had wallpaper peeling away in retention of education by SDC numerous places. How the corrective action(s) On Willow lane the following was will be monitored to ensure the deficient practice will not recur, observed: i.e., what quality assurance program will be put into place In room 220 there were light brown spots A "Facility Environmental noted on the ceiling and wall by the Review" CQI audit tool will be completed weekly x 4. Monthly x window. 2, and then quarterly thereafter by In room 222 there was numerous nicks on Housekeeping Supervisor. The the floor in varying sizes.

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155139			(X2) MU: A. BUILI B. WING	DING	OO	(X3) DATE COMPL 12/16/2	ETED
	ROVIDER OR SUPPLIER			2233 W .	DDRESS, CITY, STATE, ZIP CODE JEFFERSON ST O, IN46901		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	Р	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	In room 233 the floor board was pulling away in numerous places. 3.1-19(f)(5)				CQI committee reviews the a and action plans are develop ensure safe/clean environme threshold of 90% not met. Compliance date: January 1 2012	ed to nt if	
F0315 SS=D	assessment, the faresident who enter indwelling catheter the resident's clinic that catheterization resident who is incappropriate treatmurinary tract infectinormal bladder fur Based on observation record review, the incontinent care manner to prever (UTI'S) for 3 of 3 observed during supplemental sam (Resident #'s 2, 3). Findings include	ations, interview, and e facility failed to ensure was performed in a at urinary tract infections B supplemental residents incontinent care in a apple of 13. a, and 6) Errom 5:05 p.m. to 5:20	F03	15	F315 No Catheter, Prevent L Restore Bladder It is the pra of this provider to ensure that resident who enters the facilit without an indwelling cathete not catheterized unless the resident's clinical condition demonstrates that catheterize was necessary; and a resider who is incontinent of bladder receives appropriate treatmer and services to prevent urina tract infections and to restore much normal bladder function possible. What corrective action(s) will be accomplish for those residents found to have been affected by the	ctice i a ity r is ation nt rry as n as	01/11/2012
	containing linen the top of the car Resident #6's roo	with a basin of water on			deficient practice. Reside #2,#3,#6 have been reassess and have no signs or sympto of UTI and receive appropriating incontinent care. C.N.A. #3 been re-educated on proper	sed ms te	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155139		(X2) MULTI A. BUILDIN B. WING		00	(X3) DATE S COMPL 12/16/20	ETED	
	OF PROVIDER OR SUPPLIES		STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST				
NOR	TH WOODS VILLAGE		K	OKOMO), IN46901		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		O EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	the cart and enter Next, he was observed to the peri-area to the then replaced between the residence in the then replaced between the residence in the ten repositioned her. Resident #6's recompositioned her.	to complete her care. Ford was reviewed on p.m. The resident's ed, but were not limited disease, dementia, and so the quarterly et assessment, dated ted the resident was downward with memory problems. It is incontinent of urine ensive assistance of 1 to 2 colleting and hygiene tudies indicated a urine ined on 8/10/11 and with of Eschorichia colifaxed physician order, as Cipro milligrams by mouth 2			personal care procedure on 12-27-2011 by DNS/Designer with post test administered to evaluate the retention of education, on all shifts. How you identify other residents having the potential to be affected by the same deficie practice and what corrective action will be taken. Resider residing in this facility who has incontinence have the potential be affected by the alleged deficient practice. Licensed Nurses and C.N.A's have beer re-educated on appropriate personal care on 12-27-2011 DNS/Designee with post test administered to evaluate the retention of education, on all shifts. Non-compliance with facility policy and procedure result in employee re-education and/or disciplinary action up thand including termination. Will measures will be put into ploor what systemic changes yould make to ensure that the deficient practice does not recure. Licensed Nurses and C.N.A's have been re-educated on appropriate personal care C.N.A.'s will be checked off of Peri-Care audit sheet by DNS/Designee by 1-11-2012 all shifts. The Unit Manager and charge nurses will monited during rounds of unit for proping peri-care, on all shifts. The Director of Nursing Services a for Designee is responsible to the process.	will ent ent ents ents ive ial to len by may on, to hat ace rou led on a , on rs or er and	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155139			LDING	nstruction 00	(X3) DATE (COMPL 12/16/20	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN46901					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	washcloth from hasin, CNA #3 eroom. After rolliher diaper. At thinterview, CNA had been inconting the residents on twetters. CNA #3 wipe the resident the same area of before he put an repositioned her her care. Resident #2's rec 12/15/11 at 1:20 diagnoses includ to, dementia with quarterly minimulated 11/14/11, is severely impaired. The resident was bowel and bladde assistance of 1 to toileting and hyg. The laboratory structure was obtaindicated the grofreundii (citfre). order, dated 7/01	am data set assessment, ndicated the resident was d with memory problems. always incontinent of er and required total o 2 persons for her			monitor for compliance How corrective action(s) will be monitored to ensure the deficient practice will not rei.e., what quality assurance program will be put into plate. A "Personal Care" CQI aud tool will be utilized weekly x4 monthly x 2 and quarterly thereafter, to monitor complimite with proper personal care, or shifts. The CQI committee wereview the data. If complianted 90% threshold is not met, an action plan will be developed Non-compliance with facility policy and procedure may rein employee re-education and disciplinary action up to and including termination. Compliance date: January 2012	ecur, ince dit in ance in all ivill ise of it. sult d/or		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155139	B. WIN	G		12/16/2	011
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
NODTIL	MOODS VIII LAGE				JEFFERSON ST		
	WOODS VILLAGE				1O, IN46901		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG		ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
TAG	REGULATORT OR	LESC IDENTIFTING INFORMATION)		IAG			DATE
	a) Then CNA	#2 with alared hands wat					
		#3 with gloved hands wet ashcloth in the same wash					
		noving Resident #3's					
		eded to wipe the resident's					
		agle motion from front to					
	_	d the resident up. At this					
		g an interview, CNA #3					
	· ·	ent #3 had also been					
		rine. At this same time					
		iew, CNA #3 indicated he					
	_	with the water basin for					
		used the cart to help					
	complete his ass	-					
	complete ins ass	iginnent.					
	 Resident #3's red	cord was reviewed on					
		p.m. The resident's					
		led, but were not limited					
	_	urrent UTI's and history					
	I -	The annual minimum					
		ent, dated 11/10/11,					
		ident was severely					
		emory problems. She					
	•	ncontinent of urine and					
		red total assistance of 1 to					
	_	r toileting and hygiene					
	needs.	2 70					
		re plan, originally dated					
		dated 11/22/11, indicated					
		risk for urinary tract					
	_	to a history of UTI's,					
		ence. The approaches					
		ere not limited to, provide					
	peri care after ea	_					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155139		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 12/16/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE JEFFERSON ST IO, IN46901	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	incontinence; use barrier cream eac	e peri wash and skin ch time.					
	provided by the S	Care" policy was Staff Development 2/15/11 at 1:20 p.m. cy indicated the					
	have resident che Put on gloves Assist resident to knees if possible Wipe from from center of perineu washcloth as need For Females: Se urethral first; was labia in downwast from side to side thighs. Use differ for each stroke.	parate labia. Wash sh between and outside rd strokes, alternating and moving outward to erent part of washcloth					
	washcloth, rinse same direction a Gently pat area dwhen washingWet and soap v	ry in same direction as vashcloth from front to back, rinse					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

			NTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION OO				
AND PLAN	OF CORRECTION	155139	EK.	A. BUILE		00		COMPL 12/16/2		
		.00.00		B. WING	_	DDDEGG CITY CT	TE ZID CODE	, 10, 2	· · ·	
NAME OF P	ROVIDER OR SUPPLIER			1		DDRESS, CITY, STA JEFFERSON S				
NORTH \	WOODS VILLAGE			KOKOMO, IN46901						
(X4) ID	SUMMARY S	FATEMENT OF DEFICIEN	CIES		ID	ND OVERNOOT	AN OF CORP.		(X5)	
PREFIX		CY MUST BE PERCEDED		P	REFIX	(EACH CORRECTIVI	LAN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIAT	E	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFOR	RMATION)		TAG	DEFI	CIENCY)	_	DATE	
FORM CMS-2	567(02-99) Previous Version	ons Obsolete	Event ID: W	L BLM11	Facility II	D: 000064	If continuation sh	eet Pac	ge 19 of 26	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155139	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/16/2011
	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE JEFFERSON ST 10, IN46901	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=E	The facility must el Infection Control F a safe, sanitary an and to help prever transmission of distribution o	stablish and maintain an Program designed to provide and comfortable environment and the development and sease and infection. of Program stablish an Infection Control with the development and sease and infection. of Program stablish an Infection Control with the controls, and prevents cility; procedures, such as a papiled to an individual cord of incidents and related to infections. The add of Infection control Program resident needs isolation to do finfection, the facility esident. It is the prohibit employees with a sease or infected skin and contact with residents or contact will transmit the strequire staff to wash their direct resident contact for and is indicated by accepted			
	record review, the effective infection related to linen a	ations, interviews, and e facility failed to ensure n control practices nd handwashing, which inen closets observed	F0441	F441 Infection Control, Prev Spread, Linens It is the pract of this facility to establish and maintain an Infection Control Program designed to provide safe, sanitary and comfortable	tice d

000064

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155139		(X2) MU A. BUIL B. WING	LDING	NSTRUCTION 00	(X3) DATE S COMPLE 12/16/20	ETED	
	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN46901				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	лтЕ	(X5) COMPLETION DATE
	(CNA #1 and #3 and linen handlin observed (Reside and 2 of 6 nursin and #5) during in 10 residents observed. J. 92, and 91 to affect 35 of 16 the facility. Findings includes 1. On 12/13/11 a.m. during initial was observed on to the bed. As Completed care a room, she was observed on the sed. As Completed care a room, she was observed in the sed of th	from 4:35 a.m. to 4:47 al tour, personal clothing a Resident #41's floor next ENA #1 indicated she had and proceeded to exit the bserved to pick up the al clothing off of the ing this same initial tour, and the floor in			environment and to help pre the development and transmission of disease and infection. What corrective action(s) will be accomplis for those residents found thave been affected by the deficient practice. Reside #2,3,6,21,22,41,45,91,92,E receives personal care with proper infection control procedures for hand washing glove use, handling of linen equipment and in accordance with professional standards care. LPN's #4 and #5 and C.N.A.'s #1 and #3 have been re-educated to the hand was use of gloves, handling of linen and storage of personal belongings policy and proce with post test administered the evaluate retention of educated SDN/DNS/Designee on 12-27-2011. How will you identify other residents have the potential to be affected the same deficient practice what corrective action will taken. Residents who reside the facility have the potential affected by the alleged deficient practice. Staff has been re-educated on Infection Con Practices for proper hand washing, glove use, handling linen and storage of personal belongings with post test administered to evaluate rete of education, on all shifts, or 12-27-2011 by	hed o nt and J g, and be of d en shing, ien, dures o ion by ving by and be de in I to be ient ntrol g of al ention	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155139	B. WIN	NG		12/16/2	011
NAME OF I	PROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					JEFFERSON ST		
NORTH	WOODS VILLAGE			KOKON	MO, IN46901		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ousekeeping Supervisor			SDC/DNS/Designee. DNS responsible to ensure Infection		
	_	al coats should not be			Control practices are followe		
	hung on the insid	de door of the clean linen			What measures will be put		
	closets.				place or what systemic		
					changes you will make to		
	3. On 12/13/11	from 5:05 p.m. to 5:20			ensure that the deficient		
		ng was observed:			practice does not recur S	taff	
					has been re-educated on	.r	
	CNA #3 was obs	served to utilize an			Infection Control Practices for proper hand washing, glove		
		ontaining linen and a			handling of linen and storage		
		the top of the cart. With			personal belongings with pos		
		NA #3 was observed to			administered to evaluate rete		
	_				of education, on all shifts, on		
		by using the basin of			12-27-2011 by	lnit	
	•	of the cart. Next, he was			SDC/DNS/Designee · The L Managers and charge nurse:		
		r Resident #6's room and			monitor resident rooms and	o wiii	
		nal care. After removing			common areas for proper		
		#3 used handgel and			infection control practices on		
	_	pair of gloves. After			all shifts. · Skills check off's	for	
	wetting another	clean washcloth from his			Nurses and C.N.A's will be completed for hand washing		
	cart in the same	wash basin, CNA #3			glove use, on all shifts, by	,	
	entered Resident	#2's room and completed			DNS/Designee by 1-11-2012	<u>.</u>	
	her personal care	e. After removing his			How the corrective action(s		
	gloves, he was o	bserved to handwash.			will be monitored to ensure		
	-	onned a pair of gloves,			deficient practice will not re		
	1 '	n washcloth in the same			i.e., what quality assurance		
		completed personal care			program will be put into pla Non-compliance with facility		
	· · · · · · · · · · · · · · · · · · ·	At this same time during			policy and procedure may re	-	
		VA #3 indicated he would			in employee re-education, ar		
	· ·	omplete his assignment.			disciplinary action up to and		
		the would mix the soapy			including termination. · An	01	
		1.7			"Infection Control Review" Cotool will be utilized weekly x		
		sed when he started his			monthly x2 and then quarter		
	rounds around 4:	a.m.			thereafter to monitor complia		
					with hand washing, glove us		
	4. The "Clean	Linen" policy was					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155139			A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/16/2	ETED
		155159	B. WIN			12/10/2	011
NAME OF F	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
NODTU	WOODS VILLAGE				JEFFERSON ST		
				<u> </u>	O, IN46901		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)		TAG	linen handling and storage of		DATE
		Staff Development			personal belongings. The C		
		2/15/11 at 1:20 p.m.			committee will review the da		
	This current poli	cy indicated the			compliance of threshold of 9	0% is	
	following:				not met, an action plan will b		
					developed. Compliance dat		
	"* Protect linen	from soiling and			January 11, 2012 F223 Free)	
	contamination.				From Abuse/Involuntary Seclusion It is the practice of	of this	
	* Carts/racks s	should be covered"			facility to keep residents righ		
					be free from verbal, sexual,		
	5. On 12/13/11 f	From 8:09 a.m. to 8:35			physical and mental abuse,		
	a.m. during medi	cation pass, the			corporal punishment and		
	following was ob	oserved:			involuntary seclusion. Wha		
	LPN #4 with ung	loved hands was			corrective action(s) will be		
	_	are and administer			accomplished for those residents found to have be	Δn	
		rulin subcutaneously in			affected by the deficient	GII	
		omen area. She then			practice · Resident #153		
		edication cart and			continues to reside at the fa	cility	
	documented her				and is free from any abuse.		
					Resident #201 no longer res		
	observed used.	efore handgel was			at the facility. C.N.A. #7waterminated on 11-14-11 and		
					C.N.A.#8 was terminated on		
		epared and administered			9-23-11 · Both incidents we		
		ral medications and took			reportable events and were		
	her blood pressur	•			reported to the Indiana State	•	
	_	ndgel use was observed.			Department of Health on 12-13-11 and 9-22-11		
	_	led to prepare and			respectively. How will you		
	administer Resid				identify other residents ha	ving	
	medications. Du	ring this medication			the potential to be affected	_	
	·	ne used medication cup			the same deficient practice		
	fell on the floor.	Resident #22 requested			what corrective action will		
	the medication co	up to keep. At this same			taken · All residents residin	•	
	time during an in	terview, LPN #4			the facility have the potentia affected by the alleged defic		
	indicated she did				practice. Staff was re-educ		
		she was observed to			on the Abuse Policy at the ti		
	_	medication cup up off of			events and on 12-27-2011w		
	rion and dropped						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155139		(X2) MU A. BUILI B. WING	DING	OO	(X3) DATE S COMPLI 12/16/20	ETED	
	NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE			STREET AD	DDRESS, CITY, STATE, ZIP CODE JEFFERSON ST O, IN46901		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	Resident #22 requivalent was observed. Then, Resident # medication for head partial management was observed to and administer it mixing it with appreciation passes their hands and the preparation passes the right mid-abore observed to hand with her wet hand hands. 7. On 12/13/11 figure.	#4 was observed to lick in the plastic sleeve to in medication. LPN #4 crush the oral pain pill to the resident after plesauce. 10 p.m. during an 44 indicated during one should initially wash inen, can used handgel for the one would handwash from 11:58 a.m. to 12:05 cation pass, LPN #5 was hare and administer sulin subcutaneously in lomen. LPN #5 was wash, turn the water off d, and then, dried her from 1:20 p.m. to 1:48 cation pass, LPN #5 was hare and administer			post test administered to evaretention of education by SDC/DNS/Designee What measures will be put into ploor what systemic changes ywill make to ensure that the deficient practice does not recur. Facility will continue to tolerate any abuse to a result will be the responsibility of facility staff to monitor/observes staff mistreatment of resident Criminal background checks employment screening will continue to be done prior to employment. Staff abuse in-services will be completed upon hire and quarterly or monitore to education. Any suspected abuse allegations will be reported to the Executive Director or Director Nursing Services immediately and the employed will be suspended until investigation completed. For allegations of abuse the residual expertive outcomes and familiand physician will be notified investigation started immediately negative outcomes and familiand physician will be reported to ISDH. How the corrective action(s) will be monitored ensure the deficient practic will not recur, i.e., what quassurance program will be into place. The CQI tool "S Treatment of Resident" will be into place.	not sident of all ve for its. and ore est test ention ed orted ee rany dent v for y with ately. It is on the other to e lity put taff	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		155139	B. WIN			12/16/20)11
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			JEFFERSON ST		
NORTH	WOODS VILLAGE				10, IN46901		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	medications. In	preparation, LPN #5 was			completed weekly x4, then		
	observed to plac	e her finger inside the			monthly x2, and then quarter		
	plastic sleeve to	open it and place the oral			thereafter. • The managers charge nurses in the facility		
	^	le the sleeve 2 different			be responsible to monitor for		
		shing the oral medications			compliance. • The CQI		
	for G-tube admir				committee reviews the audit	5	
	101 G tabe admin	mismation.			monthly and action plans		
	On 12/12/11 at 1	2.10 m m dumin =			developed as needed to ens		
		2:10 p.m. during an			compliance if threshold of 90		
	-	#5 indicated one should			not met. · Non-compliance value facility policy and procedure		
		seconds, dry one's hands,			result in disciplinary action u		
	and then, turn th	e water off with the used			and including termination.		
	towels.				Compliance date: January	11,	
					2012		
	8. The following	g policies were provided					
	by the Staff Dev	elopment Coordinator on					
	1 -	p.m. These current					
	policies indicate	-					
	poneres mareate	a the following.					
	"Medication Pas	s Procedure					
	Skill:						
		following administration					
		then water) unless					
		then wash hands after"					
	resident contact	men wash hangs after					
	"Hand Washing	Skills Check					
	G1 311.						
	Skill:						
		nly, running water down					
	from wrist to fin						
	Pat dry with pap						
	Turn off faucet v	with paper towel and					
	discard towel im	mediately"					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155139		A BUILDING 00 COMPLETE		(X3) DATE SURVEY COMPLETED 12/16/2011	
NAME OF PROVIDER OR SUPPLIER NORTH WOODS VILLAGE STREET ADDRESS, CITY, STATE, ZIP CODE 2233 W JEFFERSON ST KOKOMO, IN46901					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE	
				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE